Transcript Details
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The Use and Misuse of Narcotic Pain Medication in Primary Care

Dr. Brian McDonough:
Welcome to Primary Care Today on ReachMD. I'm your host, Dr. Brian McDonough and with me today is system director of clinical pharmacy at CHE Trinity, Dr. Sean Yanchunas, as well as Dr. Jeffrey Fudin. He is the host and he writes a blog for PainDoctor.com and it's a really important program today because what I want to focus on is what I consider a major issue in health care, and that is the use of narcotic medication, perhaps the misuse of narcotic medication, and I think it'd be good for us all, especially in primary care to talk about this. Because I will start off the program by saying I'm noticing in the residency program where I teach more and more patients are coming to us who are seeking pain medication. Now some are legitimate, many are not, but the problem is they're getting pain medication from other physicians and other sources, and they more or less bring them to the practice as new patients, and we try sometimes to get people to manage the pain, and the people who manage it don't necessarily want to give them the pain medicine, they want us to do it, they want to do procedures. It's a very complicated issue and I thought it was really important to bring two experts on who could talk about the issue because I now if we're facing it, primary care doctors around the country are. So both of you, I want to welcome you, and I want to start with Dr. Fudin if I could because actually, as you know, you have a big background in pain management, and you have a website, you deal with these things. Is my reality the reality for physicians and proprietors and healthcare workers around the country?

Dr. Jeffrey Fudin:
Oh, absolutely. I mean you really hit the nail on the head. The problem is first of all education. Schools of medicine, pharmacy, nursing, nurse practitioners, they really do not dedicate enough time to pain management. When you think about it, as you said, the most common reason that patients visit any clinic, any primary care provider, is for pain management, and they just don't have the education. Most schools dedicate anywhere from two to four hours total, maybe eight at the most, and the problem is, even they people who are teaching pain management really don't have the background necessary to deal with the kind of patients that you brought up, the patient that you're not sure if they're drug seeking, you're not sure whether they really have pain, and how to interpret those things. It is a really, very, very big problem, and there is really nobody that wants...well, I shouldn't say nobody, but a lot of people don't want to treat these patients, even the pain specialists, those that are board certified in pain, most of them want to do interventions, they don't want to deal with the problem with the medication. So it is a big issue.

Dr. Brian McDonough:
I'm glad you brought that up because that is what I have seen and we're going to talk a little bit about the procedures and the need to have the pain specialists perhaps get more involved on the day to day level if they could. Sean, I want to ask you a question because I know when this subject came up I actually was speaking to you, you're a pharmacist I work with, and I was asking you a question about my shock that when I looked at top medications prescribed in the United States I saw oxycodone, Vicodin, hydromorphone, all these different medications, they're at the top. It isn't necessarily the statins anymore, it's not something I would predict, a blood pressure medication. It literally is a pain medication combo that's number one.

Dr. Sean Yanchunas:
Yeah. That's becoming very true and it's a big concern for me. I actually have someone very close to me who had surgery a few years ago and became addicted to an opiate because of that procedure. I'm very hesitant to promote the use of opioids and I think a lot of clinicians are. There's appropriate use of them. I think potentially they are being prescribed too much, there's patients that doctor shop, pharmacy shop, and a lot of these electronic healthcare records are not really talking to each other right now, and when people and the pharmacists and the physicians don't really have a really good understanding of what the patients are actually taking and where they're getting them. One of the hooks I have for the movement for the electronic medical record and health information exchange is that we

can have a better situational awareness of what's going on with these patients and understand that they're getting prescriptions from other clinicains.

Dr. Brian McDonough:
And then there's things I heard, and maybe Dr. Fudin, you can talk about this, a new drug on the market called Zohydro. Some have called it the synthetic heroin, that it's five to ten times more potent than drugs like Vicodin or Lortab. Is that really true?

Dr. Jeffrey Fudin:
No. Not really. Yes and no. Well we just heard about these medications being the most high prescribed, that's absolutely true. The most commonly prescribed drug of any drug, of any drug including penicillin is hydrocodone with acetaminophen. No question about it. If you listen to a lot of news reports and you hear a lot of people taking about it they'll say well, you know, hydrocodone is the drug that is most frequently abused. That's really only partially true, and in fact there was a great article by a fellow named Steve Butler that was published a couple years ago, and basically what they did, which we knew for a long time, is they put a denominator in the equation. So for example, yes it's true that most often we see abuse with hydrocodone. For example, when they looked at the data, hydrocodone, there was almost 600 thousand prescriptions per 100 thousand population. Oxycodone immediate release was the next one and it was like 200 thousand. The point was, there's so much hydrocodone being prescribed that yes, the drug that most often is abused is hydrocodone not because it's most abuseable, because there's more of it out there. If you correct the data for number of prescriptions written, it turns out the hydrocodone is actually the least abused of all of them based on number of prescriptions written, which is exactly opposite what you would have thought intuitively.

Dr. Brian McDonough:
But it says there's a problem here that it's being prescribed, at least from my perspective, too often. I mean if I have a complaint with emergency rooms in this country, I will say is that everybody gets a CAT scan and everybody seems to get hydrocodone/acetaminophen. I mean it's almost like you come in with sniffles and you go home with it. It's stunning.

Dr. Sean Fudin:
Oh you are 100 percent correct. I'll give you an example. My daughter went to see an ENT and she was thinking of doing a facial surgery and the surgeon gave her a prescription for 80 Percocet in case she had the surgery. My kids have been to the dentist, they get between 30 and 40 Lortabs. When they come home from having two or three molar extractions they go on anti-inflammatories because anti-inflammatories probably work better for that kind of inflammatory tissue pain from pulling a tooth out of a jaw than opiates do. So there's no question about it. It's not actually just for narcotics. I mean narcotics are potentially very dangerous, but I think we live in a society now that if somebody comes in for an ailment they expect to leave with a drug. So that is a problem.

Regarding the question you asked about Zohydro, that's actually a very interesting question about it being five to ten times more potent. That is not true. Basically Zohydro comes in a number of different strengths, 20, 30, 50 milligrams. So that milligram strength is slow release over the course of many, many hours, over 12 hours. Hydrocodone can't possibly be more potent than hydrocodone. I mean it's the same exact drug. People are saying, you see a lot of these media reports that say oh, this drug is five to ten times more potent. No. Six five milligram hydrocodone tablets is the same in potency as one 30 milligram Zohydro tablet. In fact one might make the argument that the short acting ones are potentially more dangerous because you get a higher peak, whereas with the extended release ones, they're extended over time.

And one of the big arguments is, though, well if somebody can crush this Zohydro, and that's very true, and that's one of the concerns, but there's really no data yet to support that if all of a sudden these drugs were abuse deterrent that there would be less abuse because the data has shown clearly that if you make one drug abuse deterrent then people will abuse another drug. And a great example of that is the study that I cited for you with all the hydrocodone. One of the most common drugs that's abused by crushing and snorting it is generic Opana or oxymorphone which is the breakdown product of oxycodone, and when Oxycontin became...when Purdue Pharma took Oxycontin and made it abuse deterrent so it wasn't easy to crush and snort, and so what people are looking for is a big milligram strength of a potent drug in a small line of powder that they can snort. So when Oxycontin became abuse deterrent, it was hard to crush, they started using Opana, extended-release oxymorphone because it was a very small tablet, it's twice as potent as oxycodone, it's not abuse deterrent, and it's easy to snort. So I don't think having one abuse deterrent, not abuse deterrent, I don't think it's going to change the amount of abuse that we see. It's going to cause a paradigm shift.

I mean we know that when prescription monitoring programs came into vogue and more and more states started to have prescription monitoring programs, what happened? Heroin use went up because patients were being tracked and it wasn't as easy to get pharmaceuticals so now they're using heroin, and that's what we're seeing now today.

Dr. Brian McDonough:
If you're just tuning in you're listening to Primary Care Today on ReachMD. I'm Dr. Brian McDonough, your host. My guests are Dr.

Jeffrey Fudin and Dr. Sean Yanchunas, and continuing the conversation we made some points which I think were obviously scathing and very important and maybe even damning for the healthcare system, talking about how we overprescribe these medications, but now my question is, okay, we know there's a problem, we also know that pain specialists given their choices would rather do a procedure than manage the medications for patients, and we know that most primary care docs have not been trained effectively to handle this. What do we do now? Because we have a really tough situation out there.

Dr. Sean Yanchunas:
Dr. McDonough, I think I have just a brief follow up question for Dr. Fudin that might help lead into this. He brought up the fact about patients going to clinicians and having potentially inappropriate prescribing, and one of the things on the inpatient side that clinicians have to deal with is value-based purchasing and what's called HCAHPS scores. If you have good pain scores in your hospital you get paid more, if have poor pain scores you can potentially get paid less. So I'm wondering if that is potentially driving some of this prescribing and maybe leaking out into the ambulatory setting, certainly with the things we're prescribing you have to be concerned with opiate related side effects and treating those side effects as well as people becoming addicted to these things. So I wonder what your thoughts are on that before we move onto the next thought.

Dr. Jeffrey Fudin:
I think that's a really very important question and I'm not sure what the answer is but I can tell you, just last week I was lecturing in a hospital where we weren't really talking about HCAHPS specifically but it was clear that that was a direction. So the question was, we get a patient that comes into the hospital, into the emergency room, and they're saying that they have abdominal pain, and we can't really sort out what it is, we can't make the diagnosis, and then the patient has a history of substance abuse, but we have to admit them, after all, because they do have pain. And one of the things I will say is that what's getting lost in all of this is that the poor, legitimate pain patients are having a difficult time finding treatment. So here comes a patient into the hospital that has a substance abuse problem, they get admitted to the hospital, the hospital wants to get their scores up because after all they want to get good reimbursement, they want everything to look good. In the meantime, the patient gets admitted to the floor, they don't have a diagnosis, the patient is getting IV Dilaudid or hydromorphone. Well that patient is going to love it because hydromorphone is more potent than heroin is and you give a patient like that IV push Dilaudid? That's better than heroin. So they're loving it. All right, so now they get discharged a couple of days later when you can't find anything wrong, and they go home and the cycle perpetuates, and yes, there could be situations where patients are coming to the hospital and they're being given IV push DIlaudid and they're asked to rate their pain, they're like, oh, I feel like a million bucks.

Dr. Brian McDonough:
I see that over and over again, patients will actually come up with symptoms to try to get in to get the IV Dilaudid. I mean they're coming up with I have chest pain, I have this, they're coming up with anything they can, and they start to figure out what gets them in from hospital to hospital. I mean these are all good points, but we only have about two minutes to go. What do we do? I mean we recognize now there's a problem, but primary care docs are listening, they're all over the country, all over the world, and they're saying all right, we have a problem, how do we as primary care doctors control this or even put a dent in it?

Dr. Jeffrey Fudin:
Well this is what I think needs to be done. I think as you mentioned early on, we need to have these prescription monitoring programs go across the state borders, and it's not good enough even to do that. You need to include the VA and the Department of Defense because they're like another state, and right now they're not sharing the data. But how do you fix this problem? I don't think we're ever going to fix the problem but physicians need help and there needs to be incredible amounts more of education, not only on how to legitimately treat pain and diagnosis the pain, but how to monitor these patients. You need to do urine screens, these patients need to have opiate agreements, they need to be risk stratified, there are great tools that have been validated for risk stratification, we usually use the _____ (13:32), one monitors for misuse and one is for abuse risk, and when you get the urines back you need to know how to interpret them. If a urine comes back and there's something not right in there it needs to be sent out for confirmation because those enzyme tests that are done in the physician's office or in the ER are not that accurate, and a lot of times I'll see a patient come in with a really, really high level of oxycodone in the urine so I send it out for confirmation I find that there's no metabolite. That means that the patient took the tablet and scraped it into their urine before they gave the sample, all right, because it never went through their liver. There are all kinds of things that go on and these patients that do this full time, they know exactly what to do. It's not just about learning how to diagnosis the problem. It's not just about knowing which prescription to give who. I mean it's good to give other than opioids. There are many, many drugs that can lower the dose of opioids that are required, but it's also about really, really close and careful monitoring, knowing how to interpret urines, knowing how to interpret blood levels of opioids. All of those things are almost completely missed.

Dr. Brian McDonough:
Jeff Fudin and Sean Yanchunas, I want to thank you for joining us. Unfortunately we've run out of time. Really appreciate your insights

on Primary Care Today on ReachMD, and by the way, if you missed any of this discussion, please visit ReachMD.com/primarycaretoday to download the podcast and learn more on this series. Thank you so much for listening.